		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035659

Facility Name: TAMERLANE HEALTH CARE CENTRE

Address: 3601 16 AVENUE (Number) STERLING (City) 61081 (Zip Code)

County: WHITESIDE

Telephone Number: (815) 626-0233 **Fax #** (815) 626-6740

IDPA ID Number: 36-3651798

Date of Initial License for Current Owners: 07/01/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ROBERT HEDGES
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	70	Intermediate (ICF)	70	25,550	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	70	TOTALS	70	25,550	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	22,534	1,148		23,682	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,534	1,148		23,682	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.69%

D. How many bed-hold days during this year were paid by Public Aid? _____ (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 7/01/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 7/01/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	105,064	6,256	5,581	116,901		116,901	0	116,901			1
2	Food Purchase		89,234		89,234		89,234	(192)	89,042			2
3	Housekeeping	50,547	8,503	0	59,050		59,050	0	59,050			3
4	Laundry	16,256	4,727	1,362	22,345		22,345	0	22,345			4
5	Heat and Other Utilities			41,519	41,519		41,519	693	42,212			5
6	Maintenance	33,455	4,022	20,543	58,020		58,020	7,559	65,579			6
7	Other (specify):*			2,934	2,934		2,934	34	2,968			7
8	**TOTAL General Services**	205,322	112,742	71,939	390,003	0	390,003	8,094	398,097			8
	B. Health Care and Programs											
9	Medical Director	0		9,000	9,000		9,000	0	9,000			9
10	Nursing and Medical Records	335,966	14,048	96,669	446,683		446,683	0	446,683			10
10a	Therapy	0		3,313	3,313		3,313	0	3,313			10a
11	Activities	28,786	868	0	29,654		29,654	0	29,654			11
12	Social Services	119,208		4,294	123,502		123,502	0	123,502			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			1,502	1,502		1,502	0	1,502			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	483,960	14,916	114,778	613,654	0	613,654	0	613,654			16
	C. General Administration											
17	Administrative	68,056		480,000	548,056		548,056	(437,570)	110,486			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			26,556	26,556		26,556	1,154	27,710			19
20	Dues, Fees, Subscriptions & Promotions			10,907	10,907		10,907	(1,810)	9,097			20
21	Clerical & General Office Expenses	22,105	11,501	8,903	42,509		42,509	27,129	69,638			21
22	Employee Benefits & Payroll Taxes			131,166	131,166		131,166	0	131,166			22
23	Inservice Training & Education			1,427	1,427		1,427	0	1,427			23
24	Travel and Seminar			0	0		0	1,724	1,724			24
25	Other Admin. Staff Transportation			2,969	2,969		2,969	0	2,969			25
26	Insurance-Prop.Liab.Malpractice			36,883	36,883		36,883	0	36,883			26
27	Other (specify):*			1,349	1,349		1,349	11,176	12,525			27
28	**TOTAL General Administration**	90,161	11,501	700,160	801,822	0	801,822	(398,197)	403,625			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	779,443	139,159	886,877	1,805,479	0	1,805,479	(390,103)	1,415,376			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE #0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			10,670	10,670		10,670	32,989	43,659			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			10,883	10,883		10,883	93,929	104,812			32
33	Real Estate Taxes			14,604	14,604		14,604	0	14,604			33
34	Rent-Facility & Grounds			150,540	150,540		150,540	(150,540)	0			34
35	Rent-Equipment & Vehicles			15,425	15,425		15,425	0	15,425			35
36	Other (specify):*				0		0	1,763	1,763			36
37	**TOTAL Ownership**			202,122	202,122	0	202,122	(21,859)	180,263			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			38,325	38,325		38,325	0	38,325			42
43	Other (specify):*				0		0	0	0			43
44	**TOTAL Special Cost Centers**	0	0	38,325	38,325	0	38,325	0	38,325			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	779,443	139,159	1,127,324	2,045,926	0	2,045,926	(411,962)	1,633,964			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(30)	30		9
10	Interest and Other Investment Income	(136)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(192)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(340)	21		18
19	Entertainment	0	20		19
20	Contributions	(2,060)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,349)	27		24
25	Fund Raising, Advertising and Promotional	0	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	0	20		28
29	Other-Attach Schedule SEE PAGE 5A	771			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (3,336)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(408,626)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (408,626)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (411,962)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

TAMERLANE HEALTH CARE CENTRE

ID# 0035659

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 771	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	771		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(192)	0	0	0	0	0	0	0	0	0	0	(192)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	693	0	0	0	0	0	0	0	0	0	693	5
6	Maintenance	771	6,788	0	0	0	0	0	0	0	0	0	7,559	6
7	Other (specify):*	0	34	0	0	0	0	0	0	0	0	0	34	7
8	**TOTAL General Services**	579	7,515	0	0	0	0	0	0	0	0	0	8,094	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(437,570)	0	0	0	0	0	0	0	0	0	(437,570)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,154	0	0	0	0	0	0	0	0	0	1,154	19
20	Fees, Subscriptions & Promotions	(2,060)	250	0	0	0	0	0	0	0	0	0	(1,810)	20
21	Clerical & General Office Expenses	(340)	27,469	0	0	0	0	0	0	0	0	0	27,129	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,724	0	0	0	0	0	0	0	0	0	1,724	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(1,349)	12,525	0	0	0	0	0	0	0	0	0	11,176	27
28	**TOTAL General Administration**	(3,749)	(394,448)	0	0	0	0	0	0	0	0	0	(398,197)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,170)	(386,933)	0	0	0	0	0	0	0	0	0	(390,103)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(30)	0	33,019	0	0	0	0	0	0	0	0	32,989	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(136)	0	94,065	0	0	0	0	0	0	0	0	93,929	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(150,540)	0	0	0	0	0	0	0	0	(150,540)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	704	1,059	0	0	0	0	0	0	0	0	1,763	36
37	**TOTAL Ownership**	(166)	704	(22,397)	0	0	0	0	0	0	0	0	(21,859)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(3,336)	(386,229)	(22,397)	0	0	0	0	0	0	0	0	(411,962)	45

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
WILLIAM A. IRVINE				HI CARE MGMT	SPRINGFIELD	MANAGEMENT
ROBERT HEDGES				H & I PROPERTIES	SPRINGFIELD	LANDLORD

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 480,000			$	$ (480,000)	1
2	V	5			HI CARE MANAGEMENT		693	693	2
3	V	6			HI CARE MANAGEMENT		6,788	6,788	3
4	V	7			HI CARE MANAGEMENT		34	34	4
5	V	17			HI CARE MANAGEMENT		42,430	42,430	5
6	V	20			HI CARE MANAGEMENT		250	250	6
7	V	21			HI CARE MANAGEMENT		27,469	27,469	7
8	V	27			HI CARE MANAGEMENT		12,525	12,525	8
9	V	24			HI CARE MANAGEMENT		1,724	1,724	9
10	V	19			HI CARE MANAGEMENT		1,154	1,154	10
11	V	36			HI CARE MANAGEMENT		704	704	11
12	V								12
13	V								13
14	Total			$ 480,000			$ 93,771	$ * (386,229)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 150,540			$	$ (150,540)	15
16	V	30	DEPRECIATION		H & I PROPERTIES		33,019	33,019	16
17	V	32	INTEREST		H & I PROPERTIES		94,065	94,065	17
18	V	36	AMORT.-DEFERRED MORT. COSTS		H & I PROPERTIES		1,059	1,059	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 150,540			$ 128,143	$ * (22,397)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ROBERT HEDGES								$		1
2	WILLIAM IRVINE										2
3											3
4											4
5	MARTHA IRVINE										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HI CARE MANAGEMENT
Street Address: 827 S. FIFTH STREET
City / State / Zip Code: SPRINGFIELD, IL 62703
Phone Number: (217) 528-0044
Fax Number: (217) 528-3412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	113,069	4	$ 3,308	$	23,682	$ 693	1
2	6	MAINTENANCE	PER RESIDENT DAY	113,069	4	32,407	26,833	23,682	6,788	2
3	7	SCAVENGER	PER RESIDENT DAY	113,069	4	161		23,682	34	3
4	17	OFFICER SALARIES	PER RESIDENT DAY	113,069	4	202,582	202,582	23,682	42,430	4
5	20	DUES & SUBSRIPTIONS	PER RESIDENT DAY	113,069	4	1,192		23,682	250	5
6	21	CLERICAL	PER RESIDENT DAY	113,069	4	131,151	108,009	23,682	27,469	6
7	27	INSURANCE	PER RESIDENT DAY	113,069	4	59,800		23,682	12,525	7
8	24	TRAVEL & SEMINARS	PER RESIDENT DAY	113,069	4	8,232		23,682	1,724	8
9	19	PROFESSIONAL FEES	PER RESIDENT DAY	113,069	4	5,511		23,682	1,154	9
10	36	DEPREC./AMORT. COMP .	PER RESIDENT DAY	113,069	4	3,360		23,682	704	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 447,704	$ 337,424		$ 93,771	25

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: H&I PROPERTIES, L.L.C.
Street Address: 827 S. FIFTH STREET
City / State / Zip Code: SPRINGFIELD, IL 62703
Phone Number: (217) 528-0044
Fax Number: (217) 528-3412

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 33,019	$	1	$ 33,019	1
2	32	INTEREST	DIRECT	1	1	94,065		1	94,065	2
3	36	AMORT.-DEF. MORT. COST	DIRECT	1	1	1,059		1	1,059	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 128,143	$		$ 128,143	25

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	UNITED COMMUNITY BANK		X	MORTGAGE	$12,545.00	8/7/98	$ 1,312,500	$ 1,141,478	8/6/03	0.0800	$ 94,065	1
2												2
3												3
4												4
5												5
	Working Capital											
6	ILLINI BANK		X	WORKING CAPITAL	INTEREST	REVOLV	10,000	219,300	REVOLV	PRIME+	10,440	6
7	ILLINI BANK		X	PHONE SYSTEM	$190.00	6/23/99	6,015			0.0825	109	7
8	ILLINI BANK		X	PARKING LOT	$302.00	07/18/01	9,500	8,320	07/18/04	0.0938	334	8
9	TOTAL Facility Related				$13,037.00		$ 1,338,015	$ 1,369,098			$ 104,948	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 1,338,015	$ 1,369,098			$ 104,948	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 14,106	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 14,355	2
3. Under or (over) accrual (line 2 minus line 1).		$ 249	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 14,355	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 14,604	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	14,499	8
	1997	14,734	9
	1998	14,389	10
	1999	14,106	11
	2000	14,355	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME TAMERLANE HEALTH CARE CENTRE COUNTY WHITESIDE

FACILITY IDPH LICENSE NUMBER 0035659

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-10-329-006	NURSING HOME	$ 14,355.10	$ 14,355.10
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 14,355.10	$ 14,355.10

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,130 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 0 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: 0 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	217,800	1998	$ 111,500	1
2					2
3	TOTALS	217,800		$ 111,500	3

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	70		1998	1958	$ 887,968	$ 22,769	39	$ 22,769	$	$ 76,845	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS			1992	14,227	452	31.5	452		4,184	9
10	IMPROVEMENTS			1993	3,670	94	39	94		772	10
11	IMPROVEMENTS			1994	7,850	201	39	201		1,429	11
12	PLUMBING WORK			1995	3,302	85	39	85		563	12
13	INSTALLED BOILER TANK			1995	600	15	39	15		100	13
14	INSTALL 2 PUMPS			1995	2,289	59	39	59		386	14
15	PLUMBING WORK			1995	10,752	276	39	276		1,783	15
16	DOORS			1995	2,094	54	39	54		335	16
17	TWO DOORS			1995	1,055	27	39	27		165	17
18	INSTALLED ATTIC FAN & DUCT			1995	2,412	62	39	62		375	18
19	PARKING LOT			1995	32,070	2,138	39	2,138		13,452	19
20	WALL PROTECTOR			1997	3,328	85	39	85		408	20
21	SEPTIC FIELD - PLUMBING WORK			1998	25,965	666	39	666		2,081	21
22	2 NEW WATER HEATERS			1999	12,083	310	39	310		787	22
23	CIRCUIT BREAKER PANELS			1999	2,230	57	39	57		145	23
24	ELECTRICAL WORK			1999	2,374	61	39	61		155	24
25	BREAKER PANELS			2001	2,542	50	27.5	50		50	25
26	BLACKTOP			2001	11,161	403	15	403		403	26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,027,972	$ 27,864		$ 27,864	$ 0	$ 104,418	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 55,643	$ 4,508	$ 5,278	$ 770	10 YRS	$ 35,009	71
72	Current Year Purchases	5,335	1,067	267	(800)	10 YRS	267	72
73	Fully Depreciated Assets				0			73
74	RELATED PARTY	102,500	10,250	10,250	0	10 YRS	35,875	74
75	TOTALS	$ 163,478	$ 15,825	$ 15,795	$ (30)		$ 71,151	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSKG,NSG., ACT	1994 FORD VAN	1995	$ 26,501	$	$	$ 0	5	$ 26,501	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 26,501	$ 0	$ 0	$ 0		$ 26,501	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,329,451	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 43,689	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,659	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (30)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 202,070	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 6,133 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	Chevy Suburban 2000	$ 715.00	$ 9,292	17
18					18
19					19
20					20
21	TOTAL		$ 715.00	$ 9,292	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 17,006	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	413,658		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	35,564		6
7	Other Prepaid Expenses	1,021		7
8	Accounts Receivable (owners or related parties)	83,608		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 550,857	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	140,004		15
16	Equipment, at Historical Cost	94,927		16
17	Accumulated Depreciation (book methods)	(111,408)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 123,523	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 674,380	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 231,892	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	227,620		29
30	Accrued Salaries Payable	25,952		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,066		31
32	Accrued Real Estate Taxes(Sch.IX-B)	14,355		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 508,885	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 508,885	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 165,495	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 674,380	$ 0	48

***(See instructions.)**

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 314,981	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 314,981	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(99,486)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(50,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (149,486)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 165,495	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,946,429	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,946,429	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	136	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 136	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,946,565	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	390,003	31
32	Health Care	613,654	32
33	General Administration	801,822	33
	B. Capital Expense		
34	Ownership	202,122	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	38,325	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,045,926	40
41	**Income before Income Taxes (line 30 minus line 40)****	(99,361)	41
42	**Income Taxes**	(125)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (99,486)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,038	2,259	$ 36,851	$ 16.31	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,533	1,648	28,711	17.42	3
4	Licensed Practical Nurses	6,667	7,154	113,680	15.89	4
5	Nurse Aides & Orderlies	18,897	20,433	156,724	7.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,657	1,891	15,522	8.21	9
10	Activity Assistants	2,090	2,299	13,264	5.77	10
11	Social Service Workers	12,174	13,424	119,208	8.88	11
12	Dietician					12
13	Food Service Supervisor	2,107	2,384	24,843	10.42	13
14	Head Cook	7,224	7,578	46,983	6.20	14
15	Cook Helpers/Assistants	5,176	5,549	33,238	5.99	15
16	Dishwashers					16
17	Maintenance Workers	3,861	4,115	33,455	8.13	17
18	Housekeepers	7,511	8,113	50,547	6.23	18
19	Laundry	1,499	1,726	16,256	9.42	19
20	Administrator	1,936	2,195	68,056	31.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,005	2,171	22,105	10.18	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	76,375	82,939	$ 779,443 *	$ 9.40	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 5,581	1-3	35
36	Medical Director	O	9,000	9-3	36
37	Medical Records Consultant	N	275	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,050	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	2,638	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	0	11-3	44
45	Social Service Consultant	E	2,025	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 20,569		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	444	$ 19,199	10-3	50
51	Licensed Practical Nurses	1,975	63,365	10-3	51
52	Nurse Aides	639	12,780	10-3	52
53	TOTAL (lines 50 - 52)	3,058	$ 95,344		53

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SHELLY REESE	ADMIN	0	$ 68,056
			0
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 68,056

B. Administrative - Other

Description	Amount
HI CARE MANAGEMENT	$ 480,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 480,000

C. Professional Services

Vendor/Payee	Type	Amount
ACHIEVE SOFTWARE CORP.	DATA PROCESSING	$ 4,145
HEALTHCARE HORIZONS	DATA PROCESSING	5,841
JACOBS HEALTHCARE SYS.	DATA PROCESSING	1,325
KRUPNIK BOKOR KAGDA	ACCOUNTING	14,100
PERSONNEL PLANNERS	UC CONSULTANT	1,145
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 26,556

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,345
Unemployment Compensation Insurance	6,747
FICA Taxes	59,628
Employee Health Insurance	19,590
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	13,856
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	0
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 131,166

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,903
Health Care Worker Background Check	96
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	0
RELATED PARTY-DUES	250
CONTRIBUTIONS	2,060
DUES & SUBSCRIPTIONS	6,226
LICENSES & PERMITS	422
CONTRIBUTIONS	(2,060)
Less: Public Relations Expense	(0)
Non-allowable advertising	(0)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,097

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	07/96	$ 2,402	5 YRS	$ 480	$ 480	$ 480	$ 242	$	$	$	$	$
2	PAINT/DECORATING	07/97	1,481	3 YRS	493	493	248						
3	PAINT/DECORATING	06/00	1,588	3 YRS			265	529	529	265			
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 5,471		$ 973	$ 973	$ 993	$ 771	$ 529	$ 265	$	$	$

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE # 0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ICLTC - $3794, ILHEALTH CARE-$4160**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ _____ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **38,325**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: TAMERLANE HEALTH CARE CENTRE #0035659 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,581	
	REPAIRS & MAINTENANCE		0	
			0	5,581
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,362	
			0	1,362
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		11,383	
	ELECTRICITY		24,427	
	WATER		5,291	
	CABLE TV - LOBBY		418	
			0	41,519
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,569	
	PAINTING & DECORATING		1,485	
	BUILDING REPAIRS		336	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		8,804	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		817	
	FIRE SERVICE		5,532	
			0	
			0	
			0	20,543
7	**OTHER**			
	SCAVENGER		2,934	
	SECURITY SERVICE		0	2,934
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	9,000	9,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	95,344	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2		
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	275	
	PHARMACY CONSULTANT	XVIII B 39-2	1,050	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	96,669
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		675	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,638	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	3,313
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		2,269	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	2,025	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	4,294
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number TAMERLANE HEALTH CARE CENTRE #0035659 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		1,502	1,502
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	480,000	480,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	11,311	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	15,245	
			0	26,556
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	0	
	EMPLOYEE WANT ADS	XIX F	1,903	
	CONTRIBUTIONS	VI 20 XIX F	31	
	DUES & SUBSCRIPTIONS	XIX F	6,226	
	LICENSES & PERMITS	XIX F	622	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,029	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	96	10,907
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		455	
	EQUIPMENT REPAIR & MAINTENANCE		64	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	340	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		8,044	
	MESSENGER SERVICE		0	
			0	8,903

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	59,628	
	UNEMPLOYMENT COMPENSATION	XIX D	6,747	
	WORKERS COMPENSATION INSURANC	XIX D	31,345	
	HOSPITALIZATION INSURANCE	XIX D	19,590	
	EMPLOYEE BENEFITS - OTHER	XIX D	13,856	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	131,166
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,427	1,427
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		2,969	2,969
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		36,883	36,883
27	**OTHER**			
	BAD DEBTS	VI 24	1,349	
			0	1,349

GRAND TOTAL COLUMN 3 OTHER 886,877

TAMERLANE HEALTH CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	89,234	PATIENT MEALS	71046
LESS SALES TAX	(192)	ADD EMPLOYEE MEALS	0
NET FOOD	89426	TOTAL MEALS/YEAR	71046
TOTAL PATIENT CENSUS	23,682	NET FOOD	89426
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	71046
TOTAL PATIENT MEALS	71046	COST PER MEAL	1.26
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		